

Facility Name & ID Number RENAISSANCE AT SOUTH SHORE

0042085 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 10/02/01

1	2	3	4	
Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	238	Skilled (SNF)	244	87,416
2		Skilled Pediatric (SNF/PED)		
3		Intermediate (ICF)		
4		Intermediate/DD		
5		Sheltered Care (SC)		
6		ICF/DD 16 or Less		
7	238	TOTALS	244	87,416

B. Census-For the entire report period.

1	Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Public Aid Recipient	Private Pay	4 Other	Total	
8	SNF	71,027	2,229	8,372	81,628	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	71,027	2,229	8,372	81,628	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.38%

D. How many bed-hold days during this year were paid by Public Aid? 2530 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
 YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
 YES NO

I. On what date did you start providing long term care at this location?
 Date started 10/23/98

J. Was the facility purchased or leased after January 1, 1978?
 YES Date 10/23/98 NO

K. Was the facility certified for Medicare during the reporting year?
 YES NO If YES, enter number of beds certified 83 and days of care provided 6422

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number RENAISSANCE AT SOUTH SHORE # 0042085 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	292,164	81,661	11,724	385,549		385,549	27	385,576		1
2	Food Purchase		344,633		344,633	(19,418)	325,215	(94)	325,121		2
3	Housekeeping	235,488	65,528	75	301,091		301,091		301,091		3
4	Laundry	65,252	17,313		82,565		82,565		82,565		4
5	Heat and Other Utilities			158,912	158,912		158,912	(15,400)	143,512		5
6	Maintenance	157,014	58,603	122,191	337,808		337,808	10,063	347,871		6
7	Other (specify):*							34	34		7
8	TOTAL General Services	749,918	567,738	292,902	1,610,558	(19,418)	1,591,140	(5,370)	1,585,770		8
	B. Health Care and Programs										
9	Medical Director			26,140	26,140		26,140		26,140		9
10	Nursing and Medical Records	2,685,363	177,238	427,123	3,289,724		3,289,724	942	3,290,666		10
10a	Therapy	61,188		5,371	66,559		66,559		66,559		10a
11	Activities	165,894	8,914	2,454	177,262		177,262		177,262		11
12	Social Services	63,644		3,041	66,685		66,685		66,685		12
13	Nurse Aide Training	17,967	381	2,210	20,558		20,558		20,558		13
14	Program Transportation			2,434	2,434		2,434	391	2,825		14
15	Other (specify):*							77	77		15
16	TOTAL Health Care and Programs	2,994,056	186,533	468,773	3,649,362		3,649,362	1,410	3,650,772		16
	C. General Administration										
17	Administrative	270,985		580,246	851,231		851,231	(306,383)	544,848		17
18	Directors Fees										18
19	Professional Services			125,292	125,292	(19,588)	105,704	(6,027)	99,677		19
20	Dues, Fees, Subscriptions & Promotions			140,383	140,383		140,383	(62,013)	78,370		20
21	Clerical & General Office Expenses	338,348	69,132	131,626	539,106		539,106	105,087	644,193		21
22	Employee Benefits & Payroll Taxes			696,474	696,474	19,418	715,892	(27,500)	688,392		22
23	Inservice Training & Education										23
24	Travel and Seminar			18,837	18,837		18,837	(4,470)	14,367		24
25	Other Admin. Staff Transportation			1,357	1,357		1,357	362	1,719		25
26	Insurance-Prop.Liab.Malpractice			181,313	181,313		181,313	627	181,940		26
27	Other (specify):*							33,437	33,437		27
28	TOTAL General Administration	609,333	69,132	1,875,528	2,553,993	(170)	2,553,823	(266,880)	2,286,943		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,353,307	823,403	2,637,203	7,813,913	(19,588)	7,794,325	(270,840)	7,523,485		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number **RENAISSANCE AT SOUTH SHORE**

#0042085

Report Period Beginning:

01/01/01

Ending:

12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			98,291	98,291		98,291	214,715	313,006			30
31	Amortization of Pre-Op. & Org.							6,734	6,734			31
32	Interest			119,072	119,072		119,072	694,608	813,680			32
33	Real Estate Taxes			314,269	314,269	19,588	333,857	(4,028)	329,829			33
34	Rent-Facility & Grounds			1,436,032	1,436,032		1,436,032	(1,423,812)	12,220			34
35	Rent-Equipment & Vehicles			13,073	13,073		13,073	9,209	22,282			35
36	Other (specify):*											36
37	TOTAL Ownership			1,980,737	1,980,737	19,588	2,000,325	(502,574)	1,497,751			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	14,742	224,953	41,948	281,643		281,643	43	281,686			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			131,124	131,124		131,124		131,124			42
43	Other (specify):*	13,980			13,980		13,980	(13,980)	0			43
44	TOTAL Special Cost Centers	28,722	224,953	173,072	426,747		426,747	(13,937)	412,810			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,382,029	1,048,356	4,791,012	10,221,397		10,221,397	(787,351)	9,434,046			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(232,843)	30		9
10	Interest and Other Investment Income	(180)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(94)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,000)	21		18
19	Entertainment	(6,033)	24		19
20	Contributions	(19,430)	20		20
21	Owner or Key-Man Insurance	(27,500)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(71,324)	21		24
25	Fund Raising, Advertising and Promotional	(32,462)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(12,241)	20		28
29	Other-Attach Schedule	(125,328)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (528,435)		\$	30

OHF USE ONLY					
48		49		50	
				51	
					52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(258,916)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (258,916)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (787,351)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
1			1
2			2
3			3
4			4
5			5
6			6
7			7
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10			10
11			11
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91			91

STATE OF ILLINOIS

Summary A

Facility Name & ID Number RENAISSANCE AT SOUTH SHORE# 0042085

Report Period Beginning:

01/01/01

Ending:

12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			27									27	1
2	Food Purchase	(94)											(94)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(16,245)		845									(15,400)	5
6	Maintenance		8,248	1,815									10,063	6
7	Other (specify):*			34									34	7
8	TOTAL General Services	(16,339)	8,248	2,721									(5,370)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			942									942	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation			391									391	14
15	Other (specify):*			77									77	15
16	TOTAL Health Care and Programs			1,410									1,410	16
	C. General Administration													
17	Administrative	(44,111)	44,111	1,771	(180,414)	(109,698)	(18,042)						(306,383)	17
18	Directors Fees													18
19	Professional Services	(15,180)	6,936	1,408			809						(6,027)	19
20	Fees, Subscriptions & Promotions	(69,347)		787			6,547						(62,013)	20
21	Clerical & General Office Expenses	(74,624)	1,068	175,345		1,257	2,041						105,087	21
22	Employee Benefits & Payroll Taxes	(27,500)											(27,500)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(6,033)		1,539			24						(4,470)	24
25	Other Admin. Staff Transportation			362									362	25
26	Insurance-Prop.Liab.Malpractice			627									627	26
27	Other (specify):*			25,845	3,177	371	4,044						33,437	27
28	TOTAL General Administration	(236,795)	52,115	207,684	(177,237)	(108,070)	(4,577)						(266,880)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(253,134)	60,363	211,815	(177,237)	(108,070)	(4,577)						(270,840)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number RENAISSANCE AT SOUTH SHORE# 0042085

Report Period Beginning:

01/01/01

Ending:

12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(232,843)	442,093	5,465									214,715	30
31	Amortization of Pre-Op. & Org.		6,734										6,734	31
32	Interest	(12,450)	710,222	(3,164)									694,608	32
33	Real Estate Taxes	(4,028)											(4,028)	33
34	Rent-Facility & Grounds	(12,000)	(1,424,032)	12,220									(1,423,812)	34
35	Rent-Equipment & Vehicles			9,209									9,209	35
36	Other (specify):*													36
37	TOTAL Ownership	(261,321)	(264,983)	23,730									(502,574)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers			43									43	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(13,980)											(13,980)	43
44	TOTAL Special Cost Centers	(13,980)		43									(13,937)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(528,435)	(204,620)	235,588	(177,237)	(108,070)	(4,577)						(787,351)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached		See attached		See attached		
				South Shore Limited Partnership	Chicago	Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	31 Amortization	\$	South Shore Limited Partnership	100.00%	\$ 6,734	\$ 6,734	1
2	V	30 Depreciation		South Shore Limited Partnership		442,093	442,093	2
3	V	32 Interest		South Shore Limited Partnership		722,131	722,131	3
4	V	34 Land Rent		South Shore Limited Partnership		12,000	12,000	4
5	V	19 Legal & Accounting		South Shore Limited Partnership		6,936	6,936	5
6	V	17 Management Fees		South Shore Limited Partnership		44,111	44,111	6
7	V	21 Trust Fees		South Shore Limited Partnership		250	250	7
8	V	21 State Income Tax		South Shore Limited Partnership		818	818	8
9	V	6 Repairs		South Shore Limited Partnership		8,248	8,248	9
10	V	34 Rental Income	1,436,032	South Shore Limited Partnership			(1,436,032)	10
11	V	32 Interest	11,909	South Shore Limited Partnership			(11,909)	11
12	V							12
13	V							13
14	Total		\$ 1,447,941			\$ 1,243,321	\$ * (204,620)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	<u>1</u> <u>DIETARY</u>	\$	<u>NUCARE SERVICES CORP.</u>	100.00%	\$ 27	\$	27	15
16	V	<u>5</u> <u>UTILITIES</u>		<u>NUCARE SERVICES CORP.</u>	100.00%	845		845	16
17	V	<u>6</u> <u>REPAIRS AND MAINT.</u>		<u>NUCARE SERVICES CORP.</u>	100.00%	1,815		1,815	17
18	V	<u>7</u> <u>EMPLOYEE BEN. GEN. SERV.</u>		<u>NUCARE SERVICES CORP.</u>	100.00%	34		34	18
19	V	<u>10</u> <u>NURSING ADMIN. COMP.</u>		<u>NUCARE SERVICES CORP.</u>	100.00%	942		942	19
20	V	<u>14</u> <u>PROGRAM TRANSPORTATION</u>		<u>NUCARE SERVICES CORP.</u>	100.00%	391		391	20
21	V	<u>15</u> <u>HEALTHCARE BENEFITS</u>		<u>NUCARE SERVICES CORP.</u>	100.00%	77		77	21
22	V	<u>17</u> <u>ADMINISTRATIVE - NON-OWNER</u>		<u>NUCARE SERVICES CORP.</u>	100.00%	1,771		1,771	22
23	V	<u>19</u> <u>PROFESSIONAL FEES</u>		<u>NUCARE SERVICES CORP.</u>	100.00%	1,408		1,408	23
24	V	<u>20</u> <u>FEES SUBSCRIPTIONS</u>		<u>NUCARE SERVICES CORP.</u>	100.00%	787		787	24
25	V	<u>21</u> <u>CLERICAL & GENERAL</u>		<u>NUCARE SERVICES CORP.</u>	100.00%	175,345		175,345	25
26	V	<u>24</u> <u>SEMINARS AND EDUCATION</u>		<u>NUCARE SERVICES CORP.</u>	100.00%	1,539		1,539	26
27	V	<u>25</u> <u>ADMIN. STAFF TRAVEL</u>		<u>NUCARE SERVICES CORP.</u>	100.00%	362		362	27
28	V	<u>26</u> <u>INSURANCE</u>		<u>NUCARE SERVICES CORP.</u>	100.00%	627		627	28
29	V	<u>27</u> <u>EMPLOYEE BEN. GEN. ADMIN.</u>		<u>NUCARE SERVICES CORP.</u>	100.00%	25,845		25,845	29
30	V	<u>30</u> <u>DEPRECIATION</u>		<u>NUCARE SERVICES CORP.</u>	100.00%	5,465		5,465	30
31	V	<u>32</u> <u>INTEREST EXPENSE</u>		<u>NUCARE SERVICES CORP.</u>	100.00%	(3,164)		(3,164)	31
32	V	<u>34</u> <u>BUILDING RENT</u>		<u>NUCARE SERVICES CORP.</u>	100.00%	12,220		12,220	32
33	V	<u>35</u> <u>EQUIPMENT RENTAL</u>		<u>NUCARE SERVICES CORP.</u>	100.00%	9,209		9,209	33
34	V	<u>39</u> <u>ANCILLARY</u>		<u>NUCARE SERVICES CORP.</u>	100.00%	43		43	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 235,588	\$ *	235,588	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17 ADMIN. - R. HARTMAN	\$	NUCARE SERVICES CORP.	100.00%	\$ 93,465	\$	93,465	15
16	V	17 ADMIN. - B. CARR		NUCARE SERVICES CORP.	100.00%	23,098		23,098	16
17	V	17 ADMIN. - D. HARTMAN		NUCARE SERVICES CORP.	100.00%	2,169		2,169	17
18	V	17 ADMIN. - E. DICKMAN		NUCARE SERVICES CORP.	100.00%				18
19	V	27 EMP. BEN. - R. HARTMAN		NUCARE SERVICES CORP.	100.00%	2,016		2,016	19
20	V	27 EMP. BEN. - B. CARR		NUCARE SERVICES CORP.	100.00%	992		992	20
21	V	27 EMP. BEN. - D. HARTMAN		NUCARE SERVICES CORP.	100.00%	169		169	21
22	V	27 EMP. BEN. - E. DICKMAN		NUCARE SERVICES CORP.	100.00%				22
23	V								23
24	V								24
25	V	17 MANAGEMENT FEES	299,146	NUCARE SERVICES CORP.	100.00%			(299,146)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 299,146			\$ 121,909	\$ *	(177,237)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17 J. RAJCHENBACH-COMP.	\$	JLR MANAGEMENT CORP.	100.00%	\$ 8,302	\$	8,302	15
16	V	21 OFFICE		JLR MANAGEMENT CORP.	100.00%	257		257	16
17	V	27 PAYROLL TAXES		JLR MANAGEMENT CORP.	100.00%	371		371	17
18	V								18
19	V								19
20	V								20
21	V	17 MARVIN NEEDLE-CONS. FEES		JLR MANAGEMENT CORP.	100.00%				21
22	V								22
23	V								23
24	V	17 MARK BERGER-CONS. FEES		JLR MANAGEMENT CORP.	100.00%	2,000		2,000	24
25	V	21 SECRETARIAL		JLR MANAGEMENT CORP.	100.00%	1,000		1,000	25
26	V								26
27	V								27
28	V								28
29	V	17 MANAGEMENT FEES	120,000	JLR MANAGEMENT CORP.	100.00%			(120,000)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 120,000			\$ 11,930	\$ *	(108,070)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17 ADMINISTRATIVE	\$	CAREPATH HEALTH NETWORK	100.00%	\$ 23,058	\$	23,058	15
16	V	19 PROFESSIONAL FEES		CAREPATH HEALTH NETWORK	100.00%	809		809	16
17	V	20 FEES, SUBSCRIPTIONS		CAREPATH HEALTH NETWORK	100.00%	6,547		6,547	17
18	V	21 CLERICAL AND GENERAL		CAREPATH HEALTH NETWORK	100.00%	2,041		2,041	18
19	V	24 SEMINARS		CAREPATH HEALTH NETWORK	100.00%	24		24	19
20	V	27 GEN ADMIN.- EMP. BEN.		CAREPATH HEALTH NETWORK	100.00%	4,044		4,044	20
21	V								21
22	V								22
23	V								23
24	V	17 MANAGEMENT FEES	41,100	CAREPATH HEALTH NETWORK	100.00%			(41,100)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 41,100			\$ 36,523	\$ *	(4,577)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Workers Compensation Insurance	\$ 51,054	Diamond Insurance	40.00%	\$ 51,054	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 51,054			\$ 51,054	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number RENAISSANCE AT SOUTH SHORE # 0042085 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Robert Hartman	Owner	Administrative	20.05%	See attached	4.74	7.29%	Alloc. Salary	\$ 93,465	17-7	1
2	Robert Hartman	Owner	Administrative	20.05%	See attached			Mgmt Fees	120,000	17-3	2
3	David Hartman	Relative	Administrative		See attached	0.60	1.33%	Alloc. Salary	2,169	17-7	3
4	Mark Berger	Relative	Administrator		See attached	10.00	20.00%	Salary	26,400	17-1	4
5	Mark Berger	Relative	Administrator		See attached			alloc mgmt fee	2,000	17-7	5
6	Jack Rajchenbach	Owner	Administrative	25.00%	See attached	3.00	4.62%	Alloc. Salary	8,302	17-7	6
7	Bernard Hollander	Owner	Administrative	25.00%	See attached	2.00	3.08%				7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 252,336		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number RENAISSANCE AT SOUTH SHORE

0042085

Report Period Beginning: 01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number RENAISSANCE AT SOUTH SHORE

0042085

Report Period Beginning: 01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization NUCARE SERVICES CORP.
 Street Address 6677 N LINCOLN AVENUE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 933-2600
 Fax Number (847) 933-2601

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	DIETARY	AVAIL. CENSUS DAYS	672,540	8	\$ 205	\$ 87,290	\$ 27	1	
2	5	UTILITIES	AVAIL. CENSUS DAYS	672,540	8	6,508	87,290	845	2	
3	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	672,540	8	13,988	87,290	1,815	3	
4	7	EMPLOYEE BEN. GEN. SERV.	AVAIL. CENSUS DAYS	672,540	8	258	87,290	34	4	
5	10	NURSING ADMIN. COMP.	AVAIL. CENSUS DAYS	672,540	8	7,261	87,290	942	5	
6	14	PROGRAM TRANSPORTATION	AVAIL. CENSUS DAYS	672,540	8	3,009	87,290	391	6	
7	15	HEALTHCARE BENEFITS	AVAIL. CENSUS DAYS	672,540	8	595	87,290	77	7	
8	17	ADMINISTRATIVE - NON-OWN	AVAIL. CENSUS DAYS	672,540	8	13,648	87,290	1,771	8	
9	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	672,540	8	10,851	87,290	1,408	9	
10	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	672,540	8	6,065	87,290	787	10	
11	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	672,540	8	1,350,975	87,290	1,102,702	175,345	11
12	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	672,540	8	11,855	87,290	1,539	12	
13	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	672,540	8	2,788	87,290	362	13	
14	26	INSURANCE	AVAIL. CENSUS DAYS	672,540	8	4,831	87,290	627	14	
15	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	672,540	8	199,124	87,290	25,845	15	
16	30	DEPRECIATION	AVAIL. CENSUS DAYS	672,540	8	42,107	87,290	5,465	16	
17	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	672,540	8	(24,377)	87,290	(3,164)	17	
18	34	BUILDING RENT	AVAIL. CENSUS DAYS	672,540	8	94,150	87,290	12,220	18	
19	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	672,540	8	70,953	87,290	9,209	19	
20	39	ANCILLARY	AVAIL. CENSUS DAYS	672,540	8	335	87,290	43	20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,815,129	\$ 1,114,456	\$ 235,588	25	

Facility Name & ID Number RENAISSANCE AT SOUTH SHORE

0042085

Report Period Beginning:

01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization NUCARE SERVICES CORP.
 Street Address 6677 N LINCOLN AVENUE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (847) 933-2600
 Fax Number (847) 933-2601

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED	36.52	8	720,115	720,000	4.74	93,465	1
2	17	ADMIN. - B. CARR	AVG. HOURS WORKED	40.00	8	177,679	175,000	5.20	23,098	2
3	17	ADMIN. - D. HARTMAN	AVG. HOURS WORKED	5.00	8	18,073	17,000	0.60	2,169	3
4	17	ADMIN. - E. DICKMAN	AVG. HOURS WORKED	35.00	1	20,728	19,166			4
5	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED	36.52	8	15,535		4.74	2,016	5
6	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED	40.00	8	7,632		5.20	992	6
7	27	EMP. BEN. - D. HARTMAN	AVG. HOURS WORKED	5.00	8	1,411		0.60	169	7
8	27	EMP. BEN. - E. DICKMAN	AVG. HOURS WORKED	35.00	1	1,576				8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 962,749	\$ 931,166		\$ 121,909	25

Facility Name & ID Number RENAISSANCE AT SOUTH SHORE

0042085

Report Period Beginning:

01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization JLR MANAGEMENT CORP.
 Street Address 6633 NORTH LINCOLN
 City / State / Zip Code LINCOLNWOOD, IL. 60712
 Phone Number (847) 679-9141
 Fax Number (847) 679-1820

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	J. RAJCHENBACH-COMP.	AVG. HOURS WORKED	61	9	\$ 168,808	\$ 168,808	3	\$ 8,302	1
2	21	OFFICE	AVG. HOURS WORKED	61	9	5,235		3	257	2
3	27	PAYROLL TAXES	AVG. HOURS WORKED	61	9	7,543		3	371	3
4										4
5										5
6										6
7	17	MARVIN NEEDLE-CONS. FEES	AVG. HOURS WORKED	40	1	36,296				7
8										8
9										9
10	17	MARK BERGER-CONS. FEES	AVG. HOURS WORKED	50	2	10,000		10	2,000	10
11	21	SECRETARIAL	AVG. HOURS WORKED	50	2	5,000		10	1,000	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 232,882	\$ 168,808		\$ 11,930	25

Facility Name & ID Number RENAISSANCE AT SOUTH SHORE

0042085

Report Period Beginning: 01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization CAREPATH HEALTH NETWORK
 Street Address 6633 N LINCOLN AVENUE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (888) 707-6700
 Fax Number (847) 679-2150

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	CARE PATH FEES	629,760	13	\$ 353,316	\$ 41,100	\$ 23,058	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	629,760	13	12,396	41,100	809	2
3	20	FEES, SUBSCRIPTIONS	CARE PATH FEES	629,760	13	100,317	41,100	6,547	3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	629,760	13	31,275	41,100	2,041	4
5	24	SEMINARS	CARE PATH FEES	629,760	13	366	41,100	24	5
6	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	629,760	13	61,960	41,100	4,044	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 559,630	\$ 353,316	\$ 36,523	25

Facility Name & ID Number RENAISSANCE AT SOUTH SHORE

0042085

Report Period Beginning: 01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization DIAMOND INSURANCE
 Street Address 40 SKOKIE BLVD - SUITE 105
 City / State / Zip Code NORTHBROOK, IL 60062
 Phone Number (847) 559-1002
 Fax Number ()

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Workers Compensation	Direct allocation		\$	\$		\$ 51,054	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 51,054	25

Facility Name & ID Number RENAISSANCE AT SOUTH SHORE

0042085

Report Period Beginning: 01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number RENAISSANCE AT SOUTH SHORE

0042085

Report Period Beginning: 01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number RENAISSANCE AT SOUTH SHORE

0042085

Report Period Beginning:

01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number RENAISSANCE AT SOUTH SHORE

0042085

Report Period Beginning:

01/01/01

Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	South Shore Limited Ptshp	X		Mortgage			\$	\$ 9,062,002		\$ 722,131	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6	Shareholder			Working Capital				1,980,000		119,072	6									
7											7									
8											8									
9	TOTAL Facility Related						\$	\$ 11,042,002		\$ 841,202	9									
B. Non-Facility Related*																				
10	See Supplemental Schedule									(27,522)	10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ (27,522)	14									
15	TOTALS (line 9+line14)						\$	\$ 11,042,002		\$ 813,680	15									

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number

RENAISSANCE AT SOUTH SHORE

0042085

Report Period Beginning:

01/01/01

Ending:

12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10	11											
											Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
												YES	NO				Original	Balance			
1	Interest Income		X				\$			\$	(180)	1									
2	Interest Income - Bldg Co.	X									(11,908)	2									
3	Interest Alloc. From NuCare	X									(3,164)	3									
4	Investment Income	X									(12,270)	4									
5												5									
6												6									
7												7									
8												8									
9												9									
10												10									
11												11									
12												12									
13												13									
14												14									
15												15									
16												16									
17												17									
18												18									
19												19									
20												20									
21							\$		\$		(27,522)	21									

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	\$	429,133	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	360,670	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(68,463)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	378,704	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$	19,588	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ 48,538 For 19 98 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	329,829	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1996		8
	1997		9
	1998	2,872	10
	1999	408,698	11
	2000	360,670	12
2001 Accrued Real Estate Tax = \$360,670 X 1.05 = \$378,704			
The 1998 tax bill was not used to calculate the reimbursement rate for this nursing home.			
Appeal Cost \$19,588 = \$16,225 (for 1998 tax refund) + \$3,363 (for 2000 tax reduction)			
	FOR OHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2000 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME RENAISSANCE AT SOUTH SHORE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0042085

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. <u>21-30-101-003-0000</u>	<u>Long term care nursing home property</u>	<u>\$ 28,150.43</u>	<u>\$ 28,150.43</u>
2. <u>21-30-101-004-0000</u>	<u>Long term care nursing home property</u>	<u>\$ 52,906.77</u>	<u>\$ 52,906.77</u>
3. <u>21-30-101-014-0000</u>	<u>Long term care nursing home property</u>	<u>\$ 149,263.87</u>	<u>\$ 149,263.87</u>
4. <u>21-30-101-022-0000</u>	<u>Long term care nursing home property</u>	<u>\$ 31,202.62</u>	<u>\$ 31,202.62</u>
5. <u>21-30-101-023-0000</u>	<u>Long term care nursing home property</u>	<u>\$ 99,146.61</u>	<u>\$ 99,146.61</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ 360,670.30	\$ 360,670.30

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number RENAISSANCE AT SOUTH SHORE

0042085 Report Period Beginning:

01/01/01 Ending:

12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 80,865 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: 244,947 2. Number of Years Over Which it is Being Amortized: 50
 3. Current Period Amortization: 6,734 4. Dates Incurred: 1998

Nature of Costs: Organizational cost & Mortgage cost
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>42,825</u>		<u>\$ 651,589</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	42,825		\$ 651,589	3

Facility Name & ID Number **RENAISSANCE AT SOUTH SHORE**

0042085

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				1998	\$ 9,209,684	\$ 442,094	35	\$ 263,134	\$ (178,960)	\$ 868,695	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9								-		-	9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number RENAISSANCE AT SOUTH SHORE# 0042085

Report Period Beginning:

01/01/01

Ending:

12/31/01**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$ -	\$	\$ -	37
38					-		-	38
39					-		-	39
40					-		-	40
41					-		-	41
42					-		-	42
43					-		-	43
44					-		-	44
45					-		-	45
46					-		-	46
47					-		-	47
48					-		-	48
49					-		-	49
50					-		-	50
51					-		-	51
52					-		-	52
53					-		-	53
54					-		-	54
55					-		-	55
56					-		-	56
57					-		-	57
58					-		-	58
59					-		-	59
60					-		-	60
61					-		-	61
62					-		-	62
63					-		-	63
64					-		-	64
65					-		-	65
66					-		-	66
67					-		-	67
68		3,093	159		153	(6)	385	68
69			24,403			(24,403)		69
70		\$ 9,212,777	\$ 466,656		\$ 263,287	\$ (203,369)	\$ 869,080	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RENAISSANCE AT SOUTH SHORE# 0042085

Report Period Beginning:

01/01/01

Ending:

12/31/01**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 9,212,777	\$ 466,656		\$ 263,287	\$ (203,369)	\$ 869,080	1
2	SECURITY SYSTEM	1998	12,515		20	626	626	1,982	2
3	LAWN SPRINKLERS	1998	398		20	20	20	63	3
4	LANDSCAPE ARCH	1998	2,400		20	120	120	380	4
5	BUILD PARTITIONS	1998	2,016		20	101	101	320	5
6	COMPUTER CABLING	1998	406		20	20	20	63	6
7	THERMGUARD MOUNTS	1998	1,297		20	65	65	206	7
8	LANDSCAPE ARCH	1998	6,850		20	343	343	1,086	8
9	CAR STOPS	1998	2,256		20	113	113	358	9
10	ELECTRICAL WORK	1998	1,027		20	51	51	157	10
11	WIRE PAGING SYS	1998	1,060		20	53	53	163	11
12	METAL DOOR FRAME	1998	516		20	26	26	80	12
13	WALLPAPER	1998	1,182		20	59	59	187	13
14	CARPET	1998	895		20	45	45	143	14
15	WINDOW TREATMENT	1998	12,317		20	616	616	1,951	15
16	UNDERGROUND UTIL	1998	3,000		20	150	150	463	16
17	COMPUTER CABLING	1998	277		20	14	14	43	17
18	KICK PLATES,CHAIR RA	1998	4,326		20	216	216	684	18
19	PARKING STALL MARKS	1998	325		20	16	16	49	19
20	POWER WASH PAINT	1998	800		20	40	40	123	20
21	FACILITY SIGN	1998	9,146		20	457	457	1,447	21
22	ROOM SIGNS	1998	2,181		20	109	109	345	22
23	PRINTER CABLING	1998	394		20	20	20	62	23
24	DRYING RACK	1998	3,789		20	189	189	599	24
25	SHELVES	1998	976		20	49	49	156	25
26	SHELVES	1998	1,031		20	52	52	159	26
27	FENCE	1998	1,584		20	79	79	244	27
28	KICK PLATES	1998	3,455		20	173	173	548	28
29	BANNER & SIGNS	1998	1,687		20	84	84	266	29
30	ASPHALT DRIVEWAY	1999	3,440		20	172	172	516	30
31	WIRING FOR SIGN	1999	2,717		20	136	136	408	31
32	WALLPAPER	1999	90		20	5	5	15	32
33	CARD READER ACCESS	1999	1,325		20	66	66	198	33
34	TOTAL (lines 1 thru 33)		\$ 9,298,455	\$ 466,656		\$ 267,572	\$ (199,084)	\$ 882,544	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RENAISSANCE AT SOUTH SHORE# 0042085

Report Period Beginning:

01/01/01

Ending:

12/31/01**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 9,298,455	\$ 466,656		\$ 267,572	\$ (199,084)	\$ 882,544	1
2	CCTV & INTERCOM ACCE	1999	3,585		20	179	179	537	2
3	SIGN & POSTS	1999	269		20	13	13	39	3
4	CARPET	1999	4,345		20	217	217	633	4
5	SIGNS	1999	727		20	36	36	108	5
6	OUTLETS	1999	891		20	45	45	131	6
7	PHONES	1999	2,487		20	124	124	362	7
8	CABLE & CAMERA	1999	1,560		20	78	78	228	8
9	WALLGUARD	1999	651		20	33	33	91	9
10	TOILET SEATS	1999	865		20	43	43	129	10
11	PAGER SYSTEM	1999	1,257		20	63	63	189	11
12	CANOPY	1999	1,100		20	55	55	160	12
13	LANDSCAPING	1999	24,156		20	1,208	1,208	3,221	13
14	SECURITY CAMERAS	1999	3,410		20	171	171	485	14
15	ELECTRICAL WORK	1999	3,228		20	161	161	403	15
16	WINDOW TOPS	1999	3,840		20	192	192	464	16
17	KEY SYSTEM	1999	2,920		20	146	146	341	17
18	CARPET	1999	1,135		20	57	57	133	18
19	FENCE	1999	4,500		20	225	225	525	19
20	FENCE TO PATIO AREA	1999	4,000		20	200	200	467	20
21	ELECTRICAL WORK	1999	4,900		20	245	245	551	21
22	SIGNS FOR LOT	1999	733		20	37	37	86	22
23	WALL SYSTEM	1999	2,100		20	105	105	236	23
24	HVAC INSPECTION	1999	3,279		20	164	164	355	24
25	SPRINKLERS	1999	3,335		20	167	167	431	25
26	SPRINKLERS	1999	590		20	30	30	70	26
27	IMPROVEMENT	1999	614		20	31	31	72	27
28	IMPROVEMENT	1999	671		20	34	34	79	28
29	FURNISH & INSTALL LO	2000	3,382		20	169	169	338	29
30	CABLEING	2000	1,326		20	66	66	132	30
31	FURNISH & INSTALL TI	2000	5,482		20	274	274	548	31
32	REPAIR/REPLACE AWNIN	2000	1,408		20	70	70	134	32
33	ELECTRICAL WORK IN 4	2000	2,074		20	104	104	191	33
34	TOTAL (lines 1 thru 33)		\$ 9,393,275	\$ 466,656		\$ 272,314	\$ (194,342)	\$ 894,413	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RENAISSANCE AT SOUTH SHORE

0042085

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 9,393,275	\$ 466,656		\$ 272,314	\$ (194,342)	\$ 894,413	1
2	REPLACE 2 LOCK BDS	2000	1,212		20	61	61	112	2
3	PARKING GARAGE STGE	2000	3,945		20	197	197	361	3
4	9 LATCH GRDS/DEADBLT	2000	707		20	35	35	61	4
5	FURNISH & INSTALL NE	2000	935		20	47	47	82	5
6	INSTALL NEW PHN LINE	2000	1,431		20	72	72	120	6
7	6 DUAL BED SIDE STAT	2000	541		20	27	27	43	7
8	LOWER LEVEL MAINTANC	2000	5,985		20	299	299	498	8
9	RELOCATE ELECTRICAL	2000	440		20	22	22	35	9
10	REMOTE CONTROL MOUNT	2000	932		20	47	47	74	10
11	REMOTE CONTROL MOUNT	2000	1,501		20	75	75	119	11
12	REPAIR FIRE ALARM PA	2000	841		20	42	42	63	12
13	CONTROL PANEL	2000	1,561		20	78	78	117	13
14	REPLACE WROUGHT IRON	2000	450		20	23	23	35	14
15	LOCKS, KEYS	2000	775		20	39	39	62	15
16	INSTALL LANDSCAPING	2000	972		20	49	49	69	16
17	WALL COVERING	2000	1,216		20	61	61	86	17
18	FOUNDATION FOR SIGN	2000	5,000		20	250	250	354	18
19	SIGN	2000	3,905		20	195	195	341	19
20	DAVID THOMAS MOCH	2000	696		20	35	35	44	20
21	REPLACE FREIGHT ELEV	2000	1,750		20	88	88	117	21
22	SCREENS	2000	630		20	32	32	40	22
23	LOCKS AND PASSAGE SE	2000	1,156		20	58	58	111	23
24	WALL MOUNTED DISPENS	2000	1,118		20	56	56	75	24
25	INSTALL WALL MOUNTED	2000	220		20	11	11	14	25
26	REPAIR FIRE PUMP CON	2000	570		20	29	29	41	26
27	INSTALL ADD'L WASHER	2000	787		20	39	39	46	27
28	WANDER GUARD	2000	12,600		20	630	630	1,155	28
29	PHONE TIRES	2000	1,310		20	66	66	110	29
30	WALLPAPER	2000	609		20	30	30	33	30
31	WALLPAPER	2000	1,973		20	99	99	107	31
32	ELECTRICAL WORK	2000	704		20	35	35	38	32
33	SHRAGE FENCE	2000	1,166		20	58	58	73	33
34	TOTAL (lines 1 thru 33)		\$ 9,450,913	\$ 466,656		\$ 275,199	\$ (191,457)	\$ 899,049	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RENAISSANCE AT SOUTH SHORE

0042085

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 9,450,913	\$ 466,656		\$ 275,199	\$ (191,457)	\$ 899,049	1
2	CICERO DEVELOPMENT	2000	1,292		20	65	65	70	2
3	WANDERGUARD	2001	1,341		20	67	67	67	3
4	WALLPAPER	2001	1,241		20	57	57	57	4
5	WALLPAPER	2001	608		20	28	28	28	5
6	EARL MOORE	2001	1,000		20	38	38	38	6
7	REPLACE SPRINKLERS	2001	8,791		20	440	440	440	7
8	ELECTRIC WORK	2001	2,410		20	71	71	71	8
9	CARPETING	2001	2,007		20	58	58	58	9
10	WALLPAPER	2001	897		20	26	26	26	10
11	WANDERGUARD	2001	1,045		20	30	30	30	11
12	FLOORING	2001	8,685		20	253	253	253	12
13	WANDERGUARD	2001	2,131		20	62	62	62	13
14	WANDERGUARD	2001	1,341		20	45	45	45	14
15	WANDERGUARD	2001	762		20	25	25	25	15
16	WANDERGUARD	2001	1,045		20	30	30	30	16
17	OXYGEN STORAGE CONST	2001	1,998		20	50	50	50	17
18	IRRIGATION SYS REPAI	2001	527		20	11	11	11	18
19	IRRIGATION SYS REPAI	2001	592		20	13	13	13	19
20	TILES	2001	580		20	12	12	12	20
21	PARKING LOT REPAIR	2001	6,464		20	54	54	54	21
22	WANDERGUARD	2001	779		20	13	13	13	22
23	WINTERIZE SPRINKLERS	2001	1,385		20	69	69	69	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,497,834	\$ 466,656		\$ 276,716	\$ (189,940)	\$ 900,571	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 9,497,834	\$ 466,656		\$ 276,716	\$ (189,940)	\$ 900,571	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,497,834	\$ 466,656		\$ 276,716	\$ (189,940)	\$ 900,571	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 9,497,834	\$ 466,656		\$ 276,716	\$ (189,940)	\$ 900,571	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,497,834	\$ 466,656		\$ 276,716	\$ (189,940)	\$ 900,571	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 9,497,834	\$ 466,656		\$ 276,716	\$ (189,940)	\$ 900,571	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,497,834	\$ 466,656		\$ 276,716	\$ (189,940)	\$ 900,571	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 9,497,834	\$ 466,656		\$ 276,716	\$ (189,940)	\$ 900,571	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,497,834	\$ 466,656		\$ 276,716	\$ (189,940)	\$ 900,571	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **RENAISSANCE AT SOUTH SHORE**

0042085

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Allocation from NuCare Services Corp	1997	598	15	20	30	15	126	9	
10		Allocation from NuCare Services Corp	1998	524	13	20	26	13	91	10	
11		Allocation from NuCare Services Corp	1999	734	101	20	37	(64)	89	11	
12		Allocation from NuCare Services Corp	2000	892	23	20	45	(22)	64	12	
13		Allocation from NuCare Services Corp	2001	345	7	20	15	8	15	13	
14										14	
15										15	
16										16	
17										17	
18										18	
19										19	
20										20	
21										21	
22										22	
23										23	
24										24	
25										25	
26										26	
27										27	
28										28	
29										29	
30										30	
31										31	
32										32	
33										33	
34										34	
35										35	
36										36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number **RENAISSANCE AT SOUTH SHORE**

0042085

Report Period Beginning:

01/01/01

Ending:

12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,093	\$ 159		\$ 153	\$ (50)	\$ 385	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 324,302	\$ 78,218	\$ 33,474	\$ (44,744)	10	\$ 92,480	71
72	Current Year Purchases	58,364	975	2,816	1,841	10	2,816	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 382,666	\$ 79,193	\$ 36,290	\$ (42,903)		\$ 95,296	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 10,532,089	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 545,849	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 313,006	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (232,843)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 995,867	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		244		\$			3
4	Additions							4
5	Alloc. From NuCare				12,220			5
6								6
7	TOTAL		244		\$ 12,220			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 15,802 Description: Copier \$6,593; NuCare Alloc. \$9,209

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	1999 Lexus RX300	\$ 540	\$ 6,480	17
18					18
19					19
20					20
21	TOTAL		\$ 540	\$ 6,480	21

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>/2002</u>	\$ _____
13.	<u>/2003</u>	\$ _____
14.	<u>/2004</u>	\$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE <u>120</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE <u>80</u></p>
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B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
1	Community College Tuition	\$ 170	\$ 2,040	\$	\$ 2,210
2	Books and Supplies	25	356		381
3	Classroom Wages (a)	1,382	16,584		17,967
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$ 1,578	\$ 18,980	\$	\$ 20,558
10	SUM OF line 9, col. 1 and 2 (e)	\$ 20,558			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	<u>12</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	<u>1</u>
2. From other facilities (f)	
TOTAL TRAINED	13

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 4,589	\$		\$ 4,589	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			721			721	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			8,449			8,449	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 03	# of prescripts			28,189	151,635		179,824	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):			14,742			73,318		88,060	13
14	TOTAL			\$ 14,742		\$ 41,948	\$ 224,953		\$ 281,643	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number RENAISSANCE AT SOUTH SHORE

0042085

Report Period Beginning: 01/01/01

Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 39,506	\$ 178,584	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,498,709	4,498,709	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	85,817	85,817	6
7	Other Prepaid Expenses	15,494	15,494	7
8	Accounts Receivable (owners or related parties)	140,566	140,566	8
9	Other(specify): See supplemental schedule	482,817	659,267	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,262,909	\$ 5,578,437	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		651,589	13
14	Buildings, at Historical Cost		8,876,834	14
15	Leasehold Improvements, at Historical Cost	933,260	933,260	15
16	Equipment, at Historical Cost	354,656	1,189,748	16
17	Accumulated Depreciation (book methods)	(282,875)	(1,691,315)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		244,947	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(18,382)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	290,389	290,389	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,295,430	\$ 10,477,070	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,558,339	\$ 16,055,507	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,130,363	\$ 2,130,363	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	542	542	28
29	Short-Term Notes Payable	1,980,000	1,980,000	29
30	Accrued Salaries Payable	294,562	294,562	30
31	Accrued Taxes Payable (excluding real estate taxes)	29,545	29,545	31
32	Accrued Real Estate Taxes(Sch.IX-B)	378,704	378,704	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	1,985,786	2,085,753	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,799,502	\$ 6,899,469	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,062,002	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 9,062,002	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,799,502	\$ 15,961,471	46
47	TOTAL EQUITY(page 18, line 24)	\$ (241,163)	\$ 94,036	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,558,339	\$ 16,055,507	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,822,164)	1
2	Restatements (describe):		2
3	See attached	(120,487)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,942,651)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,701,488	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,701,488	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (241,163)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number RENAISSANCE AT SOUTH SHORE

0042085

Report Period Beginning: 01/01/01

Ending:

12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,954,909	1
2	Discounts and Allowances for all Levels	(104,842)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,850,067	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	652,449	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 652,449	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	237,162	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	63,193	19
20	Radiology and X-Ray		20
21	Other Medical Services	59,026	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 359,381	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	12,450	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,450	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See supplemental schedule</u>	48,538	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 48,538	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,922,885	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,610,558	31
32	Health Care	3,649,362	32
33	General Administration	2,553,993	33
B. Capital Expense			
34	Ownership	1,980,737	34
C. Ancillary Expense			
35	Special Cost Centers	295,623	35
36	Provider Participation Fee	131,124	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,221,397	40
41	Income before Income Taxes (line 30 minus line 40)**	1,701,488	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,701,488	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash basis If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number RENAISSANCE AT SOUTH SHORE

0042085

Report Period Beginning:

01/01/01

Ending:

12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,192	2,257	\$ 82,139	\$ 36.39	1
2	Assistant Director of Nursing	2,722	2,838	68,735	24.22	2
3	Registered Nurses	22,828	24,751	542,308	21.91	3
4	Licensed Practical Nurses	37,059	39,110	707,000	18.08	4
5	Nurse Aides & Orderlies	134,196	141,464	1,191,694	8.42	5
6	Nurse Aide Trainees	2,880	2,880	17,967	6.24	6
7	Licensed Therapist	1,193	1,193	14,742	12.36	7
8	Rehab/Therapy Aides	6,892	7,180	61,188	8.52	8
9	Activity Director	3,776	4,047	65,840	16.27	9
10	Activity Assistants	12,984	14,047	100,054	7.12	10
11	Social Service Workers	5,175	5,671	63,644	11.22	11
12	Dietician	4,537	4,888	80,364	16.44	12
13	Food Service Supervisor					13
14	Head Cook	5,533	5,897	53,989	9.16	14
15	Cook Helpers/Assistants	23,246	24,211	157,811	6.52	15
16	Dishwashers					16
17	Maintenance Workers	9,258	9,994	157,014	15.71	17
18	Housekeepers	32,788	34,109	235,488	6.90	18
19	Laundry	8,145	9,070	65,252	7.19	19
20	Administrator	2,093	2,246	101,734	45.30	20
21	Assistant Administrator	3,562	3,651	72,743	19.92	21
22	Other Administrative	3,936	3,936	96,508	24.52	22
23	Office Manager					23
24	Clerical	22,059	23,719	338,348	14.26	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,271	5,176	93,487	18.06	31
32	Other Health Care(specify)					32
33	Other(specify)	544	544	13,980	25.70	33
34	TOTAL (lines 1 - 33)	351,868	372,880	\$ 4,382,029 *	\$ 11.75	34

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	267	\$ 11,724	01-03	35
36	Medical Director	Flat Rate	26,140	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	4	200	10-03	38
39	Pharmacist Consultant	Flat Rate	2,976	10-03	39
40	Physical Therapy Consultant	64	2,388	10a-03	40
41	Occupational Therapy Consultant	67	2,404	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	19	579	10a-03	43
44	Activity Consultant	45	2,454	11-03	44
45	Social Service Consultant	60	3,041	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	526	\$ 51,906		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	2,783	\$ 120,414	10-03	50
51	Licensed Practical Nurses	1,222	303,270	10-03	51
52	Nurse Aides	4	263	10-03	52
53	TOTAL (lines 50 - 52)	4,009	\$ 423,947		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number RENAISSANCE AT SOUTH SHORE

0042085

Report Period Beginning:

01/01/01

Ending:

12/31/01

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL Council of Long Term Care \$13,934
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 38,103 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 131,124
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 19,418 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%ln14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees